PROMISING PRACTICES IN HOME AND COMMUNITY-BASED SERVICES

Florida – Providing Managed Care Organizations with Financial Incentives to Expand Community Care and Limit Nursing Home Care

Issue: Long Term Care Community Diversion

Summary

This report describes a managed long-term care pilot project in the State of Florida that encourages coordination of acute and long-term care services for people age 65 or older with disabilities. A salient feature of the pilot is that participating HMOs must absorb the costs of lifetime nursing home care, should it be required for individuals enrolled in the pilot. The pilot has low disenrollment and serves a more impaired population in the community than the state's largest Medicaid HCBS waiver for older people and people with disabilities.

Introduction

This report briefly describes a managed long-term care pilot project the State of Florida has initiated to test a Medicaid managed care program that includes incentives for coordinating acute and long-term care and for using less expensive, community-based alternatives to nursing homes. The pilot is available, in selected locations, for individuals age 65 or older with disabilities.

The pilot project was driven by the findings of a Long-Term Care Commission in 1994–1995. The commission concluded that current funding levels would only meet 70% of older people's demand for publicly funded long-term care in 2010. The commission also noted that people who use long-term care often need acute medical services, yet these services usually are not effectively coordinated. Coordination is important to avoid service duplication and to ensure that persons' needs are comprehensively met – yet is difficult because Medicare pays for most acute care and Medicaid pays for most publicly funded long-term care.

This document describes the managed care pilot, how it is being implemented, and results known at this time. It is based on written materials produced by the State of Florida, an independent evaluation by the University of South Florida's Florida Policy Exchange Center on Aging, interviews with state staff in charge of implementing the managed long-term care program, interviews with the staff of Health Maintenance Organizations (HMOs) participating in the pilot, and the HMOs' Web sites.

Background

Prior to the pilot, older people with disabilities could access Medicaid home and community-based services through three different mechanisms. Most people use home and community-based services (HCBS) waivers on a fee-for-service basis (i.e., providers are paid for each service). In South Florida, however, older people have two managed care options featuring increased coordination of services and provider incentives to contain costs. In one option, a case management organization is paid the same dollar amount per person per month (a capitated rate) for home and community-based services, but has no financial responsibility for acute or nursing home care. In the other option, an HMO coordinates all Medicaid services, including the portion of acute care paid by Medicaid. However, the HMO is only responsible for nursing home

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payments until the end of the state's fiscal year. In both managed care options, the state is still responsible for long-term nursing home costs.

Intervention

In the pilot project, formally named the "Long-Term Care Community Diversion Pilot Project," the state pays participating HMOs a capitated rate for all Medicaid services, including acute health care services not paid by Medicare and home and community-based services. The HMOs are liable for unlimited nursing home payments for as long as the person remains enrolled. As a result, there are strong incentives to reduce nursing home usage in order to reduce costs. Participating HMOs employ case managers to coordinate acute and long-term care. The HMOs also offer new benefits to help reduce nursing home usage. Examples of such benefits include nutritional assessments, family training, and part of assisted living room and board expenses. These benefits are in addition to the acute and long-term care services covered by Medicaid and by Florida's fee-for-service HCBS waivers, which participating HMOs are required to offer.

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Enrollment in the pilot is voluntary. A person can leave the pilot at the end of any month. HMOs must accept an applicant if the person is eligible and chooses to enroll in the pilot. State staff help people complete the paperwork needed to enroll in one of the pilot HMOs.

The enrollment process is similar to the process used to access Florida's fee-for-service HCBS waivers. Individuals request and receive a Comprehensive Assessment and Review for Long Term Care Services (CARES) assessment from the local Area Agency on Aging. A person qualifies for the program if he or she is at least 65 years old, lives in one of pilot areas, lives in the community, and requires a nursing home level of care. The person must also be eligible for Medicaid and Medicare. Medicare eligibility is required even though the pilot does not pay for Medicare services. If the person qualifies for the program, he or she may choose fee-for-service HCBS waiver services or the pilot program.

The HMOs must provide a face-to-face orientation with each person within two weeks of enrollment. At the orientation, the person receives a consumer handbook that includes the HMO's benefit package, an explanation of the case manager's role, a provider directory, information regarding health care advance directives, and information about the person's rights and responsibilities.

HMOs assign a case manager to each person. The case manager must develop a plan of care that identifies how each person will remain in the community, including the home and community-based services the HMO will provide. Registered nurses are available in each HMO to either review entire care plans or consult with the case manager on medical issues. Participants have the right to appeal the case manager's decisions regarding the plan of care, either through the HMO's appeals process or can request a fair hearing through the Florida Department of Elder Affairs. Case managers also work with the person's physicians and pharmacists to review the appropriateness of the person's medications. Case managers coordinate medical appointments and arrange for transportation to those appointments.

Implementation

The pilot is being implemented in four counties. The pilot began in Orange, Osceola and Seminole counties in 1998; and in Palm Beach County in 1999. Two HMOs are participating in Palm Beach County, and another participates in the three remaining counties.

Two factors helped Florida implement the pilot. First, Florida had some prior experience with managed long-term care models. Second, a 1995 Robert Wood Johnson Foundation grant paid for part of the program's development.

The pilot makes one HMO responsible for all Medicaid services, and some of these HMOs also offer Medicare managed care plans. Florida had hoped most people in the pilot would choose one HMO to provide both Medicare and Medicaid services. The pilot was implemented, however, at a time when HMOs throughout the country reduced the number of counties in which

they offered Medicare services. One participating HMO discontinued all of its Medicare HMO options in the pilot area. Thus, only in Palm Beach County can people choose the same HMO for both Medicare and Medicaid benefits.

In fiscal year 2001, each HMO participating in the pilot received approximately $2,300 per person per month for all Medicaid benefits. This payment is higher than the payment for Florida's other Medicaid managed care options to reflect the increased liability the HMOs face for nursing home admissions. The pilot's $23 million budget provides enough funding to serve an average of 800 people. The pilot currently serves this number and has a waiting list.

The pilot serves a more impaired population than a comparable fee-for-service Medicaid waiver.

Impact

Interviews with state staff and an independent evaluation show some evidence of the pilot's effectiveness. State staff report less than eight percent of current participants are in nursing homes. People rarely choose to leave the pilot: each HMO had a disenrollment rate of two or three percent per month in state fiscal years 2000 and 2001, and more than half of disenrollments were not voluntary (e.g., due to death or loss of Medicaid eligibility).

According to the evaluation, a sample of people enrolled in the pilot who lived in their own homes reported fewer unmet needs than a sample of people using Florida's largest fee-for-service waiver for older people and people with disabilities, the Aged/Disabled Adult Waiver, in the same counties. The evaluation also concluded the pilot serves a more impaired population than the Aged/Disabled Adult Waiver, and that people enrolled in the pilot are less likely to live with an informal caregiver than people using the Aged/Disabled Adult Waiver.

Contact Information

For more information about the Long-Term Care Community Diversion Pilot Project, please contact Anne Frost in Florida's Department of Elder Affairs at (850) 414-2308 or frostac@elderaffairs.org. Information about Florida's long-term care programs is available on the Internet at **http://www.myflorida.com**.

Key Questions:

How can one determine the efforts to coordinate acute and long-term care services are successful?

What specific interventions are used by the HMOs to reduce nursing home admissions?

One of a series of reports by The MEDSTAT Group for the U.S. Centers for Medicare & Medicaid Services (CMS) highlighting promising practices in home and community-based services. The entire series will be available online at CMS' web site, http://www.cms.gov. This report is intended to share information about different approaches to offering home and community-based services. This report is not an endorsement of any practice.